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# AMERICAN PRACTITIONER:

A MONTHLY JOURNAL OF

## MEDICINE AND SURGERY.

EDITED BY

DAVID W. YANDELL, M. D.
*Professor of Clinical Surgery in the University of Louisville,*

AND

THEOPHILUS PARVIN, M. D., LL.D.
*Late Professor of the Medical and Surgical Diseases of Women, University of Louisville.*

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# CONTENTS.

ORIGINAL COMMUNICATIONS:

CASE OF RECONSTRUCTION OF THE MOUTH, AFTER LOSS OF THE UNDER LIP, BY A NEW OPERATION. BY GURDON BUCK, M. D..... 65

ON CHOLERA AND CHOLERA INFANTUM. BY E. R. PALMER, M. D. ..... 75

UTERINE HYDATIDS—FATAL TERMINATION. BY J. OWEN WALL, M. D..... 79

REVIEWS ..... 85

CLINIC OF THE MONTH..... 97

NOTES AND QUERIES..... 119

BIBLIOGRAPHY ..... 127

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# THE AMERICAN PRACTITIONER:

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## MEDICINE AND SURGERY.

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# THE AMERICAN PRACTITIONER.

## AUGUST, 1873.


Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

## Original Communications.

### CASE OF RECONSTRUCTION OF THE MOUTH, AFTER LOSS OF THE UNDER LIP, BY A NEW OPERATION.*


BY GURDON BUCK, M. D.,

*Visiting Surgeon of the New York Hospital and Presbyterian Hospital; Consulting Surgeon to St. Luke's Hospital and Roosevelt Hospital.*


Hugh B., a resident of New York City, aged thirteen years, of rather slender constitution, though ordinarily enjoying good health, came under surgical treatment in October, 1869, in consequence of the loss of the entire under lip following an attack of scarlatina, of which his mother gave the following account.

When six years old he was taken sick with scarlet fever, and became dangerously ill. The eruption was scanty, and in other respects the disease was irregular in its development. Sloughing of the lip succeeded, and with it inflammation, involving the parts around the lower jaw on both sides.

*Communicated at the annual meeting of the New York State Medical Society, February, 1873.

Necrosis followed, and considerable portions of the maxilla were cast off.

The condition of his face when I first saw him was as follows: The entire under lip was gone, and the skin below the lip on the right side of the chin had been destroyed to within a finger's breadth of the edge of the jaw. On the left side of the chin the destruction of the parts had not extended as low down. The upper lip was of ample dimensions, and both angles of the mouth were entire and somewhat drawn down by the contraction of the neighboring parts during cicatrization. The right half of the tongue adhered by its under surface to the floor of the mouth as far forward as the alveolar border of the maxilla in front. Its extremity also was held fast, and was exposed to view from the absence of the under lip. That portion of the body of the lower jaw which is situated between the symphysis and last molar tooth of the right side had previously come away entire, and the alveolar sockets of all the teeth belonging to it could be identified; the last molar tooth alone still remained *in situ* inside the mouth. A much smaller portion from the left half of the jaw also exfoliated. It consisted of alveolar border supporting the sockets of the two bicuspid and two neighboring molar teeth. The extensive loss of bone on the right side has been quite perfectly supplied by new bony product along the inferior border of the maxilla; thereby a solid support is afforded and the symmetrical form of the face preserved. The canine tooth is the only one remaining *in situ* in the left half of the lower jaw, and the last molar the only one in the right half. Articulation is but little affected. The

FIG. 1. Right half of the body of the lower jaw.

FIG. 2. Portion of alveolar border from the left half of the lower jaw.

patient suffers the greatest discomfort and annoyance by the constant flow of saliva from the mouth. Owing to the deficiency of teeth he has been restricted to the use of liquid and soft solid food. His general health is good.

FIG. 3. Patient's condition before any operation was performed. The under lip is entirely gone and the end of the tongue exposed to view.

### FIRST OPERATION.

The first operation was performed on the 6th of October, 1869, at the patient's residence, with the aid of Prof. A. C. Post and Drs. Bell and Beekman. Ether anæsthesia was employed in this as in all subsequent operations. The procedure was as follows: The right cheek was detached from the lower jaw, on the inside of the mouth, backward to a point a little beyond the edge of the masseter muscle, and downward to the lower edge of the jaw-bone. An incision, commencing upon the right cheek at a point below the middle of the zygoma, was carried downward and forward in a curved direction, with its convexity looking posteriorly to a point half an inch below the angle of the mouth. After turning up the flap thus formed and exposing the cavity of the mouth, I divided the mucous membrane along the anterior edge of the masseter muscle upward to the malar process, and thence forward along the line where it quits the maxilla to cover the inside of the cheek as far as the upper canine tooth. This liberation of the parts permitted the entire flap to be glided forward edgewise till its anterior edge reached the symphysis. The same procedure

was executed on the left side of the face. The arteries were secured as fast as they were encountered, thus avoiding hemorrhage as much as possible. The skin remaining upon the chin was pared symmetrically into an angular form, the angle pointing upward and situated in the median line. The two cheek-flaps were now glided forward edgewise and made to meet by their anterior edges at the symphysis, where they were secured together by two pin-sutures below and three fine thread-sutures at the lip-border. On either side of this line of junction, where the cheek-flaps came together in the median line, their inferior edges stood astride of the angle of integument upon the chin, and were secured to it by sutures. This adjustment had the effect of folding the upper lip upon itself and obliterating the angles of the mouth, besides causing the folded upper lip to overhang the retracted under lip. The surfaces left bare on both cheeks by this transfer of the cheek-flaps were covered by advancing the skin from the posterior edge of the wound after dissecting it up from its subjacent connections. No raw surface therefore remained after securing these edges together by sutures. Notwithstanding the extensive incisions required in this operation, the hemorrhage was moderate, and was not followed by any marked depression of the pulse. A single attack of vomiting, which emptied the stomach of the blood swallowed during the operation, was the only disturbance occasioned by the long-continued administration of the ether. To maintain the warmth of the parts they were protected with a covering of woven lint. The inflammatory tumefaction that followed during the three or four days succeeding the operation was moderate, as was also the febrile reaction. On the second day I began removing the alternate thread-sutures and changing the yarn on the pins. Special care was required to maintain in close contact the edges of the flaps, where they met together over the symphysis menti and along on both sides of the chin, where the saliva was liable to escape between

the sutures. On the right side of the chin, where the tongue was in contact with the parts on the inside of the mouth, and exerted some forward pressure, saliva did escape between the sutures and prevented adhesion from taking place. At all other points primary union was secured. To accomplish it, however, fresh pins as well as fresh sutures had to be inserted at those points where the old ones were beginning to excite suppuration by their prolonged presence. The administration of nourishment was managed by his mother, whose long experience enabled her to do it very successfully. On the right side of the chin, union having failed to take place for a distance of about two inches from the symphysis, it became necessary to resort to another operation for the closure of the aperture.

### Second Operation.

October 30th—Both edges of the opening remaining on the right side of the chin having cicatrized, they were pared afresh. The lower edge was dissected up from the jaw to facilitate its eversion, and the upper edge was cut across at both ends for the same purpose. The two edges were then accurately confronted and secured together by six pin-sutures and nine intermediate silver wire sutures. By this means the wound was made impermeable to saliva.

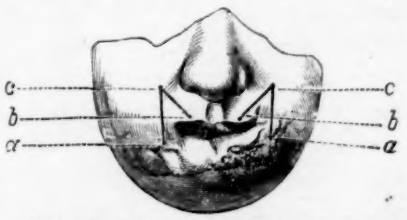


Fig. 4. The new mouth; upper lip, folded upon itself, protruding and overhanging the short, retracted under lip.

November 4th—The last suture was removed to-day, and union found to have taken place at all points except one, where an opening of the size of a goose-quill allowed the saliva still to escape.

November 15th—Under repeated applications of nitrate of silver, and the constant support afforded by adhesive plaster, the opening has now permanently healed.

The mouth as now reconstructed presents a somewhat circular form; the upper lip being folded upon itself, increased in thickness, and overhanging the under lip, which is retracted and tense. To restore the angular shape of the mouth and equalize the length of the two lips was the object to be accomplished by the following operation, which was performed on the 30th of November.

### Third Operation.*

The method of performing this operation is new and differs essentially from any hitherto described in the annals of operative surgery. To secure the utmost precision in making the requisite incisions, their course was first designated by pins temporarily inserted erect in the skin. For example, on either side of the chin a pin was inserted at a finger's breadth below and to the outside of the mouth, and located so that both should be equidistant from the median line and on the same horizontal level (*a a*, fig. 4.) A pin was also inserted at the margin of the vermilion border of the upper lip on either side, so that both pins should be equidistant from the median line, and at such a distance apart as would leave between the two pins sufficient length of lip-border to form a new upper lip (*b b*). By aid of the fore-finger of the left hand, placed on the inside of the mouth, the left cheek was kept moderately on the stretch, while with a sharp-pointed Beer's cornea-knife it was transfixed at the point *a*, marked by the lower pin on the left side of the chin. The incision was carried through the cheek upward and a little outward, a distance of one inch and a half, to a point near the middle of the cheek (*c*). The left half of the upper lip was then transfixed at the point *b*, marked by a pin on the vermilion border, and an incision carried through the lip and cheek outward and

* Dr. J. A. Estlander, Professor in Helsingford (in Langenbeck's Archives, 14 Band, 3 Heft, 1872), has reported an operation for supplying loss of the lip somewhat similar to the author's.

a little upward to join the first incision at its terminus (*c*) in the middle of the cheek. A triangular patch was thus formed, which included the entire thickness of the cheek, having its apex free and disconnected, while its base remained attached on the side toward the mouth. The next step was to transfer this patch from the cheek to the side of the chin. For this purpose an incision was made on the side of the chin from the starting-point (*a*) of the first incision downward to the edge of the jaw and to the depth of the periosteum. The edges of this incision, yawning wide apart, afforded a V-shaped space for the lodgment of the triangular patch, which was then brought round edgewise and adjusted by sutures in its new locality. By this transfer the portion of upper-lip border which formed a part of the base of the patch was brought into a transverse line continuous with the under lip, and constituting an extension of it. The space upon the cheek from which the triangular patch had been taken was then closed, by bringing its edges together and securing them in contact by sutures. By this adjustment of the parts a new angle was formed for the left side of the mouth at the point *b* on its vermilion border, where the upper lip had been transfixed. The left half of the mouth thus reconstructed presented a natural shape, and consisted of natural lip-border with lining mucous membrane.

### Fourth Operation.

On the 4th of January, 1870, the same operation was applied to the right side of the mouth. Some fear was entertained that sloughing might take place on this side of the face, from the presence of numerous cicatricial lines resulting from previous operations. Nevertheless primary union followed the operation as it did the preceding, except at the apex of the triangular patch in its new locality on the right side of the chin, where a slough formed, and was in due time cast off. The extent of the slough was, however, so limited as not at

all to impair the result of the operation. At the end of the third day the last suture was removed, and strips of adhesive plaster were applied to support the newly-united parts. The final result obtained by these two operations was the restoration of the mouth to its natural shape, except at one point in the right half of the under-lip border, where a notch still existed and permitted the saliva to escape uncontrolled from the mouth. This defect in the result of the last operation was owing partly to an original deficiency of material on the right side of the chin, and partly to the right half of the under-lip border having dropped below the level of the left half in uniting with it in the median line. The patient spent the following summer in the country, and returned to the city in October much improved in health. The parts involved in the previous operations had also improved; they, as well as the cicatricial lines intersecting them, had regained a good degree of softness and pliability.

FIG. 5. Condition at this time.

FIFTH OPERATION.

October 5, 1870—The design of this operation was to fill up the notch on the under-lip border. It was executed as follows: The border of the notch was split lengthwise vertically through its middle, and the edges on both sides of the split were pared off beveling, so as to increase the thickness of the fresh-cut surface. The upper lip was then transfixed at the middle of its right half, and an incision carried toward and around the right angle of the mouth, so as to detach a strip of lip-border half an inch wide, including the angle with which to fill up the notch. The strip was brought around lengthwise and secured to the fresh-cut edge of the notch by fine thread-sutures inserted close together. This operation diminished materially the defect in the right half of the under lip, but did not entirely prevent the escape of

saliva. At the same time, however, the operation had diminished the dimensions of the mouth, and converted the angle on the right side of the mouth to a circular turn. These defects rendered further operative procedures necessary.

### Sixth Operation.

April 12, 1871 — The object of this operation was the restoration of the angular shape of the mouth on the right side. It was accomplished by carrying an incision very accurately along the line separating the vermilion border from the skin around the circular half of the mouth, and extending to an equal distance on the upper and lower lips. The incision penetrated to the depth of the mucous membrane on the inside of the lip, but did not divide it. A sharp-pointed, double-edged knife was then inserted between the skin and mucous membrane at the middle of the incision, and, being directed flatwise toward the cheek, was made to separate them from each other in the direction in which the mouth was to be enlarged. The detached skin was thus first divided with strong scissors on a line with the commissure of the mouth and to a distance of three quarters of an inch. The underlying mucous membrane was next divided in the same direction, but not as far out as the skin. The skin and mucous membrane were then secured together by a single thread suture passed through them at the angles of the incisions just made. A new lip-border was then shaped above and below by paring the edges first of the skin, then of the mucous membrane, in such a manner that the latter would overlap the former after they had been secured together by fine thread-sutures inserted at short intervals. A good result followed, and the natural angular shape of the mouth was restored.

Again the patient spent the summer in the country, and on his return to the city, in September, a further improvement in the condition of his face was observable. Still, however, the mouth, though restored to its natural angular shape on

the right side, was scanty in length. A shallow notch in the right half of the under-lip border also still remained, and allowed some escape of saliva, especially when the head was inclined forward and his attention was not directed to controlling it. After a little persuasion, seconded by his mother's influence, the patient consented to a final operation for the remedying of the defects still remaining. It was performed on the 23d of September, 1871, as follows.

### Seventh Operation.

The first step of the operation was to enlarge the mouth on the right side by extending the angle further outward. This was accomplished by repeating the sixth operation as just described. The next step was to obliterate the notch on the right half of the under-lip border. To accomplish this the following operation was performed: Two incisions, commencing on either side of the notch a little below the lip-border, and extending through the entire thickness of the lip, were carried downward in converging lines that met below the chin. The included triangular patch, having for its base the notched portion of the lip-border, and retaining its connection for support on both sides of the notch, was pushed upward, and secured on a higher level by bringing together the edges of the wound below the patch, and securing them in contact by a pin-suture wound with cotton-

Fig. 6. Condition in March, 1872.

yarn. A second pin-suture was inserted higher up and made to traverse both edges of the wound, as well as the patch interposed between them; an additional thread-suture below completed the adjustment. Primary union without any suppuration followed, and on the third day the last suture was removed.

The final result of these operations is that the patient's mouth is of natural shape, symmetrical, and of good dimensions. The saliva no longer escapes uncontrolled. The lips perform their natural motions, and articulation is not at all affected. Fig. 6, representing his condition in March, 1872, was engraved from a photograph. At the present time—March, 1873—still further improvement is noticeable. The numerous cicatricial lines, intersecting the surface on both sides of the chin and cheeks, have shrunken to the level of the adjacent surface, and they, as well as the skin itself, are perfectly supple and pliable.

NEW YORK.

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## ON CHOLERA AND CHOLERA INFANTUM.

BY EDWARD R. PALMER, M. D.,
*Professor of Physiology in the University of Louisville.*

Two cases of malignant cholera have lately come under my observation in this city. The first occurred on the 2d and the second on the 3d of July. They were attended by Dr. Manly and myself. Prof. Bell saw the second case in consultation with us.

The subject of the first case was a young lady, aged twenty-eight years. She was taken during the night of July 1st with vomiting and purging. She was seen by Dr. Manly at daylight, July 2d, when the vomiting and purging had ceased. Collapse had taken place. No pulse was perceptible

beyond an occasional quiver of the carotids; restlessness a prominent symptom, with death at eight A. M. I saw the case between six and seven A. M.

The second patient was the father of the young lady, and had nursed her throughout her last illness. After her death he went out in town, exposed to the great heat of the midday sun, to make arrangements for the funeral. At two o'clock I was sent for, and found him lying down, breathing rapidly, somewhat hoarse, with a rapid, feeble pulse, and anxious expression of countenance. He had just returned from the privy, and had discovered his exhaustion in climbing the stairs to his room. I ordered at once the "chloroform paregoric" which is recommended by Dr. Hartshorne in his "Essentials;" also sent for Dr. Manly. It is needless to follow the case either as regards the treatment on the one hand or the march to dissolution on the other. He died the next day at about one o'clock P. M.

My object in writing this brief article is not to add to the already long history of ineffectual struggles which the profession is too often called upon to make against this rapidly fatal malady; but I have some observations, or more properly some reflections, which I wish to submit to my professional brethren.

Cholera, I am convinced, is no more identical with cholera morbus, nor any more due to a like cause, than is small-pox with pneumonia. The one is clearly due to a specific poison inhaled, the other to the action of non-specific causes. Their prevalence at the same time is simply a coincidence, nothing more. Purging and vomiting constitute the disease in cholera morbus, and when this disease proves fatal it is due to exhaustion from these actions. Purging and vomiting, though usually present, may be entirely absent, and are, relatively speaking, minor symptoms in true cholera.

Suppression of urine, so often spoken of in connection with cholera, may occur or may not, though the former is

almost invariably the case. When it does it is not, strictly speaking, the cause of death, but is one of the effects of the specific cause which is crippling other and quite as important functions. Nor is inspissation of the blood entitled to the prominence it holds among the causes of death. The blood certainly fails to circulate, and that usually to a great extent some hours before death.

Cholera appears to be in its essence the result of some unknown specific poison acting upon the ganglionic system of nerves. It is a "ganglionic tetanus," and whenever *cured* it must be by such agents as will relax this spasm of the vaso-motor and other ganglionic nerves. The purging, the vomiting, the inspissation of the blood, the urinary suppression, these will all, if present, demand attention; but the cholera, which kills without any of these phenomena, may also carry off the patient after the relief of these symptoms. I can not better explain what I mean than by comparing my second case with one of cholera morbus which I had under treatment at the same time.

The cholera case looked malignant from the start. The countenance was changed to an anxious expression; was pinched and blue; the whole surface was blue and shriveled; the pulse speedily became thready, and in ten or twelve hours was lost; the extremities became cold about the same time; the voice was first husky, and then was lost in a few hours. During the first twelve hours urine was voided regularly; after that not at all. Purging and vomiting were tolerably frequent during the first twelve hours, but ceased, as we believed, under the effect of treatment at the end of that time, after which whisky, brandy, egg-nog, milk, and water were taken and retained. The cerebro-spinal system did not appear to take any part in the affection. Death from collapse resulted in twenty-four hours after the attack. The case throughout reminded me more of one of fatal poisoning than any thing else.

The cholera-morbus case began at ten P. M. of July 2d, the same day and in the same neighborhood as the case of cholera. I saw the patient, an adult man, at eleven P. M. It was a fearful case, the vomiting and purging far exceeding that of the cholera case. Abdominal and crural cramps were well marked; skin cool, but not cold; pulse all the way through full, though latterly feeble. These symptoms, with slight improvement, lasted nearly twenty-four hours, when they gave place to a good sleep, and the case was ended. It was attended by no collapse, no cessation of pulse, no loss of voice, no shriveling, no *iciness* of the extremities, and none of that ugly blueness which marks cholera. So different was this and every other case of cholera morbus (some twenty or thirty in number) which I have seen this summer from the cholera cases, that I felt no hesitation, even when the vomiting, purging, and cramping were almost incessant, in promising a certain recovery. As for cholera, as I have already said, it is not the purging, vomiting, etc., but the *ganglionic tetanus* that kills.

### Cholera Infantum.

Previous numbers of the practitioner have contained articles highly commendatory of the calomel and of the bismuth and pepsin treatment of cholera infantum. I have tried both, and am fully convinced of their inferiority in this disease to the creosote and lead treatment. In the treatment of a large number of cases during the last three summers but one has proved fatal, and that one was in a state of complete collapse before it was seen. The formula used is as follows:

℞. Mucilaginis acaciæ, . . . ℥ ss;
Liquoris calcis, . . . ℥ iss;
Creosoti, . . . . . gtt. iij;
Plumbi acetatis, . . . . gr. xvj.
S. A tea-spoonful every one to three hours.

One thing proved is the innocuousness of the acetate, no symptom of lead-poisoning having in any instance resulted.

A former professor of chemistry in this city was in the habit of asserting that sugar of lead might be given in scruple or half-drachm doses without any toxic effect, which seems, though contrary to general opinion, exceedingly plausible.

Egg-water—the white of one egg to each gobletful—is given in conjunction with the above treatment. By adding a good-sized pinch of bicarbonate of soda to each glassful the retention of this drink by the stomach is almost assured.

Finally, in the above reference is had to those cases only which are strictly cholera infantum, entero-colitis being excluded as a disease which during its protracted course usually needs a variety of treatment. Here too, however, creosote and lead will give great satisfaction. My object in this note is not the promulgation of a *new* treatment; but, if possible, to strengthen a good old one, and claim again for the use of sugar of lead freedom from the danger of lead-poisoning.

LOUISVILLE.

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## UTERINE HYDATIDS—FATAL TERMINATION.

BY J. OWEN WALL, M. D.

On the 30th of January I was called to visit Mrs. S., in consequence of her suffering with profuse uterine hemorrhage. The lady was forty-three years of age, had borne eleven children, the youngest being two years old. She had slight uterine pain. The body of the uterus was as large as at the fifth or sixth month of pregnancy. By local applications and position, and by morphia internally, the pains and flow were promptly arrested. The next day she was in comfortable condition, though she had slight hemorrhage during the previous night. As her general health was poor, tonics, etc., were prescribed. Soon after nausea and vomiting oc-

curred, and neither food nor medicine could be retained, but these were slightly relieved by a blister to the epigastrium dressed with morphia. Her history until March 3d was marked by a persistence of the irritability of the stomach, by occasional attacks of hemorrhage, and by a rapid increase in the size of the abdomen. At that date most severe hemorrhage took place, apparently in consequence of her getting out of bed and walking to the fire. The flow was so great as to cause syncope. Emptying the vagina of clotted blood, I found the os uteri slightly dilated, and a soft mass protruding from it, which upon removal was found to be composed of vesicles varying in size from that of a filbert to that of a small gooseberry. Of course the diagnosis was plain, and I determined to empty the uterus. A large dose of fluid extract of ergot was followed by vigorous uterine contractions, but the hemorrhage was so great that a tampon was used for its arrest. The next day I found her restless, skin parched, pulse 140, and very feeble. The tampon was removed. There had been no dilatation, and there was no hemorrhage. Ordered beef-tea, wine-whey, etc., hoping she would rally before further interference was necessary.

On March 5th the pain and hemorrhage returned, though the latter was not great. Found the os uteri freely dilated, and a hydatidiform mass protruding from it. As the uterine contractions were feeble, ergot was given, and in less than half an hour the mass referred to was expelled, followed by a large fleshy mole. The hydatids were discharged partly in clusters and partly detached, the entire quantity filling a large chamber-pot. Hemorrhage was not great until the discharge of the last of the hydatids, but then was profuse. It was arrested by ergot, cold, compression, etc., and the womb contracted well. I left her, after ordering nutritious food and stimulants, only to be summoned in a brief time, in consequence of a return of pain and flooding, to her bedside, and found her dead.

Such is a brief history of a case which is extraordinary because of the rarity of its occurrence, and because of the almost entire impossibility of making a positive diagnosis prior to the discharge of some of the characteristic vesicles. The two symptoms most relied upon in the diagnosis of uterine hydatids were present in this case; viz., the rapid increase in the size of the womb, and the repeated attacks of hemorrhage. The persistent nausea and vomiting from which my patient suffered I have not found mentioned as characteristic of this disease, but think them of considerable importance taken in conjunction with the other symptoms.

Cazeaux met with but three cases in his extensive practice, and in but one of them could a diagnosis be made out. He advised puncture and ergot; the patient died. Meigs speaks of having seen several cases, but is not clear in either diagnosis or treatment. He does not speak of diagnosing a case previous to the discharge of vesicles. He deprecates the production of "any body's labor." Churchill advises non-interference "until uterine effort commences," and that repeated hemorrhages to any great extent should be controlled by the tampon and cold cloths; if these fail he advises ergot. Ergot failing to bring on contractions, he would decide on "manual interference by the size of the uterine distension. If that be equal to pregnancy at seven months, the hand may be introduced and mole brought away; but if under that size, we run risk of doing more mischief by being meddlesome than would result if patient were left alone." In the management of a case such as has just been detailed, is the physician justified in emptying the womb whether an unequivocal diagnosis can be made or not? In reply I will say that were I called to a similar case I should not hesitate to operate at once. In justice to myself I will remark that I was not deceived in the nature of the case, and that I communicated my opinion to the friends of the patient three weeks previous to the discharge of vesicles, notwithstanding I did not feel

justified in operating, as the attacks of hemorrhage were easily controlled. Other reflections suggest themselves, but this paper would be protracted beyond the design of the writer.

HUNTINGTON, W. VA.

*Remarks.* We feel greatly indebted to Dr. Wall for reporting the above case. It is hardly necessary to remind our readers that, as Dr. Graily Hewitt remarks, true hydatids of the uterus is a disease almost unknown in pathology, and there is perhaps not more than one quite authentic case on record. Dr. Hewitt reports such a case in the twelfth volume of the "Transactions of the London Obstetrical Society." In it the vesicles varied in size from a small pea to a walnut. They were distinct from each other. In the fluid which escaped from the cyst, and on the cyst wall, were found minute white bodies, which upon microscopic examination proved to be echinococci heads, having a rhomboidal shape, with a circle of hooklets in the center of the head. Nor is it necessary to state that the profession for some years have been agreed in regarding the ordinary form in which so-called hydatids of the uterus occur as resulting from cystic degeneration of the chorion.

Dr. Wall refers to the nausea and vomiting, which in such a marked degree characterized his case, as symptoms unnoticed by writers on the subject. In the seventh volume of the "London Obstetrical Society's Transactions" Dr. Robert Barnes reports a case where these conditions existed. So too in the second volume of the "Edinburgh Obstetrical Transactions," Dr. Rattray, in narrating a case occurring in his practice, gives the following statement: "Sickness continued both day and night for fully three months, whereas in previous pregnancies vomiting commenced as soon as she became *enciente*, and continued for the first month, but only during the day." And in two of four cases reported by Boivin and

Duges vomiting is mentioned as one of the symptoms. Nevertheless there does not seem any reason for anticipating that nausea and vomiting should be any more necessarily consequent upon hydatigenous degeneration of the ovum than upon normal pregnancy. In the one, as in the other case, these may be most distressing and persistent, or present in but a slight degree. Still Dr. McClintock, an extract from whose work we shall give in a moment, makes "persistent vomiting" one of the symptoms, although certainly some cases have been reported where this condition is not so much as alluded to.

Dr. McClintock states that "although the *diagnosis* of cystic disease of the ovum can rarely be made until the expulsion of some of the vesicles has taken place, still there are certain symptoms whose presence in a suspected case would form a very just ground for believing that the uterus contained hydatids. The early history of nearly all these cases is that of pregnancy up to a certain period, when the ordinary symptoms of this state disappear and are replaced by others, or to the ordinary symptoms are superadded some new and unusual ones. Persistent vomiting, unusual hardness of the uterine tumor, a disproportionate size of the latter to the supposed duration of pregnancy, irregular or sudden discharges of reddish water, are, I believe, the most reliable indications of the presence of this disease."

Once the disease is recognized, we have nothing better or more briefly given as to treatment than that of Dr. Thomas, in his work on "Diseases of Women:" first, full dilatation of the cervical canal by tents and Barnes's dilators; and second, cause the expulsion of the mass by ergot, or remove it with a scoop, looped wire, or other appropriate instrument. Possibly approval of the latter part of this advice might be qualified by suggesting that the fingers or the hand first, and then fenestrated forceps, if necessary, might be better than scoops or curved wires; and finally, that the tampon may be a necessity when the uterus is but slightly emptied,

and that injections of a solution of perchloride or persulphate of iron may be equally necessary subsequently.

Is a fatal result to be anticipated in these cases? Not ordinarily; recovery is the rule, death the exception. Nevertheless there are several fatal cases on record, especially where the diseased condition co-existed with albuminuria. It would be interesting to know whether this was the fact in Dr. Wall's patient.

What was the fleshy mole Dr. W. reports as expelled with the last of the hydatids? Boivin and Duges, in one of their cases, speak of there "coming after the last bunch of hydatids a spongy mass similar to a putrefied placenta." This probably was not the fact in Dr. W.'s case, and probably the true explanation of the occurrence of this supposed mole is that it really was a mole; that a twin pregnancy had occurred, and each embryo died: the hydatidgenous mass told of one, the fleshy mole of the other. Nor is this hypothesis at all irrational. In the third volume of the "London Obstetrical Transactions" Dr. J. Hall Davis gives "a case of hydatid mole expelled from the uterus immediately after a living fetus and placenta, at about six months of gestation, the hydatid growth being the degenerated ovum of a twin conception."

In concluding, we must again thank Dr. Wall for having furnished a report of this case. T. P.

# Reviews.

**Refraction and Accommodation:** A Review of Dr. D. S. Reynolds's Critique on Dr. C. S. Fenner's Pamphlet.

The July number of this journal contains a review by my friend, Dr. Reynolds, of a short article on Refraction and Accommodation, written by myself; and I beg a brief space to reply here to some of the criticisms made by Dr. Reynolds. I shall confine myself largely to extracts from established authorities. The reviewer says:

"Our author, on the first page, makes this remark: 'Many cases of amblyopia that a few years since would have been considered as incurable are now entirely relieved by neutralizing the aberrations of refraction by appropriate lenses.' We had been under the impression until now that amblyopia in its various forms belonged to the retina and not to the refracting media. In fact Dr. Bull, a distinguished specialist of New York, and many others, the writer among the number, have during the past two years been experimenting with strychnine hypodermically in the hope of curing this too often intractable disease; and we have even thought that in some cases of amblyopia arising from disuse of the eye, on account of squint, occlusion of the pupil, and the like, after removing the cause of the disuse, the strychnine did good, and might take rank as a curative agent."

I do not see the bearing that the "experimenting with strychnine hypodermically in the hope of curing this too-often intractable disease" has on the assertion that many cases of amblyopia are relieved by neutralizing the errors of refraction by appropriate lenses. The Doctor states that he "had been under the impression until now that amblyopia in its various forms belonged to the retina and not to the

refracting media." That I have good authority for the assertion that I make, I refer the Doctor to the following extracts from the excellent work of Soelberg Wells. On page 481* he will find that Wells says: "For it is now known that certain forms of asthenopia and *amblyopia*, which had in former times set all remedies at defiance, are *not due*, as was generally supposed, to *serious lesions of the inner tunics of the eyeball, but are in reality dependent upon some anomaly of the* refraction of the *eye, or a peculiar assymmetry of the organ* (astigmatism). *Since the discovery of these important facts a considerable group of cases have been found to be amenable* to treatment; cases which had formerly sorely puzzled the oculist, and were by him *too often deemed incurable.*"

Again the same author (page 515), under the head of astigmatism, says: "Donders has shown that it is of frequent occurrence, and that *many cases of congenital amblyopia are due to it, and may be cured by proper cylindrical glasses.*" The reviewer next proceeds as follows:

"In the next sentence after the one devoted to the subject of amblyopia we are told by the author that 'it is definitely settled that the inherent power possessed by the eye of adapting itself to see an object clearly and distinctly at different distances is due to the voluntary action of the ciliary muscle on the crystalline lens, causing the latter to change its curvatures as the object approaches or recedes from the eye, so that within certain limits diverging rays coming from it are united in a focus on the retina.'

"We had always supposed that union of the rays constituted the focus, no matter where that union occurs, whether 'in a focus on the retina' or *in* any thing else. It is indeed generally believed and taught by most of the eminent oculists that the ciliary muscle is one of the prime factors in the production of the accommodative effort; but this is not definitely settled, to say nothing of that muscle's power to 'act on the crystalline lens.' . . . . . .

*The edition of Wells's Treatise on the Eye from which I make these extracts is the one published by H. C. Lea, Philadelphia, 1869, and edited by Dr. J. Minis Hayes. The italics are my own, introduced to call attention to special points.

Many other authorities might be cited to show that it *has not been 'definitely settled* that the ciliary muscle acts on the crystalline lens' *so as to produce any effect on the accommodation of the eye whatever.*"

To prove the correctness of my assertions I again refer to Wells (page 492). He says: "It has at length been *definitely settled*, chiefly by the experiments of Cramer and Helmholtz, that the necessary change in the refraction of the eye during accommodation is due to an *alteration* in the *form* of the *crystalline lens.*" On page 493 he adds: "The question now arises, in what manner is *this change in the form of the lens* produced? There can be *no doubt now* that it is *entirely due* to the *action of the ciliary muscle.*" In Stellwag's work on the eye (page 575) he says: "The variations in the amount of adjustment of the dioptric apparatus is caused *solely* by *changes* of *curvature* of the lens *(Cramer, Helmholtz).* The *causes* of these *changes* are the *action of the ciliary muscle* and the great elasticity of the normal crystalline lens when the capsule is uninjured." He further states this *action* of the ciliary muscle *on the lens* continues when the eye is in a state of rest. On page 577 we find the following: "Like all other muscles, the muscle of accommodation has a certain tonicity, which causes its *action* on the *convexity of the lens* to continue while at rest." The question that is *not definitely settled* is as to the *manner* in which the ciliary muscle acts so as to produce changes in the convexity of the lens, whether or not this action is direct or indirect. Stellwag (page 576) says: "The *exact manner* in which the ciliary muscle causes an *increased convexity of the lens* is *still uncertain;*" and then he goes on to give the views entertained by physiologists. Donders (p. 26) says: "It therefore remains only to attribute to the musculus ciliaris the important quality of accommodation muscle; . . . but the mechanism whereby the contraction of *this little muscle alters* the *form* of *the lens* is not yet satisfactorily and convincingly brought to light." I think the above extracts are sufficient to prove to the readers of

the Practitioner, if not to the reviewer, that it will be a difficult matter for him to "show that it *has not been 'definitely settled that the ciliary muscle acts on the crystalline lens' so as to produce any effect in the accommodation of the eye whatever.*"

The following assertion in the review as applied to accommodation—"We had always supposed that union of the rays constituted the focus, no matter where that union occurs, whether 'in a focus on the retina' *or in any thing else*"—I do not comprehend, nor what he means by "or *in* any thing else." The entire object of accommodation is to unite rays of light emanating from a body placed at different distances from the eye in a focus on the sensitive layers of the retina, so that a distinct and well-defined image of the object may be formed on that delicate structure.

Notwithstanding Dr. R. differs with me, I still adhere to the opinion that the forced contraction of the recti muscles has a very decided effect on the accommodation of the eye, as illustrated by the experiment that I suggest (page 13) for one to try on his own eye. I may be in error as to the manner in which the forced uniform contraction of these muscles act on the eye, so as to render very fine print clear, distinct, and largely magnified when held an inch from the cornea; and I shall gladly accept any explanation more satisfactory than the one that I have given. But to show that there is nothing new or particularly startling in the announcement of my belief that a strong uniform contraction of the recti muscles slightly increases the length of the eye in the direction of its optic axis, and which the reviewer assures us "is known to produce just the contrary effect," I quote the following from Mr. Laurence: "Le Camens, Shroeder, Von der Kolk, and Arlt were advocates for the power of the extrinsic muscles of the eye, the recti and obliqui, producing accommodation by *elongating the axis of the globe.*" The reviewer refers to Donders to show that hypermetropes may often be recognized by their "*retracted*" eyes, as follows:

"Almost all late writers, and especially Donders, say that hypermetropes may often be recognized by their *retracted* eyes; *thus proving at once, without further argument,* that *contraction* of the *recti muscles consentaneously* is equivalent* to a *perceptible* diminution of the antero-posterior diameter of the eyeball."

Now I differ with Dr. R.; I do not think the "*retracted*" eyes of hypermetropes prove any thing one way or the other on the subject under consideration. Donders says: "The rule is, however, that hypermetropia depends on a peculiar typical structure of the eye, which may be called the *hypermetropic structure.* The hypermetropically-formed eye is a *small eye;* in all its dimensions less than the emmetropic eye, but especially in that of the visual axis. . . . The hypermetropic eye is in general an *imperfectly-developed eye.* . . . The hypermetropic structure is *hereditary.* . . . Thus the *orbit* is *less deep,* and to this corresponds a smaller eye, with a *shorter axis* of vision, which again in its turn is connected with a *shallower socket.*" Now I do not see how this "typical," "imperfectly developed," "small," "*retracted*" eye, "with a shorter axis of vision," and connected with a "shallower socket," proves "at once," "*without further argument,*" that a perceptible diminution of the antero-posterior diameter of the eyeball is "*equivalent*" to contraction of the recti muscles consentaneously. The Doctor continues thus:

"The following statement is made by Dr. Fenner: 'I am satisfied that in this country, particularly in the South and West, the normal visual angle is less than five minutes. From a large number of tests, I have found that most persons have clear and sharp sight with a visual angle of four minutes. In Germany, and some other European countries, the inhabitants are proverbially short-sighted. An angle of five minutes is the smallest one (except in small children) at which they can ordinarily see with distinctness.'"

To which he adds this: "Then, according to this, Snellen's

* I am not positive that I understand correctly the meaning of the expression "contraction of the recti muscles *consentaneously.*" Webster defines consentaneously to mean agreeably; consistently; suitably.

test-types are improperly graded for the determination of the acuity of vision."

An angle of five minutes is the one universally adopted "as the standard for determining the acuteness of vision, and the test-types of Snellen and Girard Tuelon have been devised upon this principle." It is a well-known fact that the angle of five minutes was adopted as a standard of measurement, because it was the smallest one at which the majority of the inhabitants where these tests were first constructed or devised could see with distinctness. Hence, as Stellwag remarks, "it is usually considered as the normal angle." Now, if the majority of the inhabitants of another nation or class of people see distinctly at a smaller angle, I see no impropriety in calling that particular angle the normal one for that nation or class of people. I would not by any means make any change in the angle of five degrees as a standard of measurement; for to do so it would create the same confusion that now exists in the measurement of distances by English, French, or Prussian feet and inches, or in the different standards of nations as to the values of gold and silver coin.

We pass to page 11 of the review for the following extract in order that it may appear in connection with the subject of test-types:

"Just here, before dismissing the subject of test-types, we would mention that those now in almost universal use were devised by Snellen, a Dutchman of Utrecht. (*It is important to note that he is not a German.*)"

Query: who has accused Snellen of being a German? (I hope the reader will bear this "*important*" fact in mind that Snellen is a *Dutchman*, and not a *German*.) He continues:

"So then it appears that the Dutch and Hindoos, as well as Americans, have superior vision to the Germans. But, unfortunately for Dr. Fenner's *discovery*, Snellen is not a German, but a Dutchman, living *in* and writing *at* Utrecht, in Holland. Donders likewise gives us in his estimate the state of vision possessed by

his own countrymen, viz., the Dutch; so that it does not appear where our author learned that they (the Germans) are 'proverbially near-sighted.'"

(Here we have another announcement of the vitally "important" fact that "Snellen is not a German, but a Dutchman, living *in* and writing *at* Utrecht, in Holland.")

The great number of young persons in Germany wearing near-sighted glasses is the subject of remark by most travelers in that country, and Donders says: "Myopia is not equally prevalent in all countries. It is certainly more especially proper to cultivated nations. . . . . Among the states of Europe visited by me I, both in *general life* and in the *cliniques*, nowhere met *relatively* so many myopes as in Germany." The above extract shows that Donders has snatched from me the *honors of discovery* that my excellent but perhaps too partial friend so generously awards me.

Dr. R. continues as follows:

"Under the head of astigmatism Dr. F. says (page 22) that to detect this 'Graefe invented an optometer, composed of fine wires crossing each other at right-angles.' The Philosophical Transactions for 1793 inform us that Thos. Young, the discoverer of astigmatism, made use of the wire optometer in the examination of his own eye. Graefe was born thirty-five years after the use of the wire optometer was published to the world by Dr. Young."

It is well known that Young used a wire optometer for determining astigmatism in his own eye; and it is equally well known that Von Graefe devised the instrument known as "Von Graefe's wire optometer," a description of which is given by Wells, who says that "the best objects for testing the range of accommodation are Snellen's test-types or Von Graefe's wire optometer." I hope the interests of science will not seriously suffer because I have stated that Graefe "invented" the wire optometer that bears his name.

Our reviewer, in a pamphlet issued by him (entitled "The Ophthalmoscope," etc., by D. S. Reynolds, M. D., 1872), in-

forms us that "Helmholtz announced his *discovery*, in 1851, of an *instrument*, by the proper use of which," etc. . . . . And that "this great *discovery*" of the instrument "*remained* for the first four years almost exclusively in the *hands* of the German ophthalmologists." On the next page he informs us that "there has been more than thirty *inventors* of ophthalmoscopes." Is there any thing strange then that there should have been two persons who invented different forms of wire optometers, even if one lived thirty-five years after the other?

Next we have the following startling announcement, which some would think sensational:

"But we pass now to the *most remarkable of the many remarkable statements* contained in this treatise. Under the head of 'remarks' this occurs: 'For most of our knowledge of the diseases of refraction and accommodation we are indebted to the researches of that wonderful people, the Germans. . . . . Among those worthy of all honor in connection with the subjects of this article I would mention Helmholtz, Donders, Graefe, Knapp, Arlt, Stellwag, Jaeger, and Hering, who, with their fellow co-laborers, have in less than a quarter of a century built up an entirely new science in this department of ophthalmology.'"

After the above extract I find some four pages devoted to a *resumé* of history. Now I have not the least objection to the Doctor's writing history, which in the present instance is correctly given, as any can testify who will read the historical remarks of certain authors; but these four pages of history have no bearing whatever on the *article* under review, for the latter nowhere states when, where, or by whom the diseases of refraction and accommodation were DISCOVERED.

That I am not alone in my estimate of the value of the contributions to ophthalmological science by the Germans, I quote from Charles E. Hackley and D. B. St. John Roosa, translators and American editors of Stellwag's great work on the eye, as follows: "Moreover, without disregarding the great assistance rendered by English and French surgeons,

we must consider the present *advanced position* of ophthalmology as due in a *great measure* to the *labors of the Germans.*" Graefe was a German, and Herr Max King says of him: "*We may affirm without exaggeration that the recent extraordinary development* in ophthalmology *took its rise chiefly from Graefe's own person and labors.*"

It is really a matter of small importance, so far as the interests of science are concerned, what may be the nationality of those laboring in her behalf, as long as mankind has the benefit of those labors. The contributions of Donders and Snellen are equally valuable whether these distinguished men may be Germans or Dutchmen. As before stated, I do not see any bearing that this *resumé* of history has on any thing that is to be found in the article under review, as nothing is said in the latter in reference to the "discovery" "of the matters treated of;" and I certainly learned myself more than a "quarter of a century" ago, from books placed in my hands as a student, that such matters existed; but it is *since* that time that science "celebrates her triumph," and our knowledge of this department has "acquired the exact character which makes it also worthy the attention of natural philosophers and physiologists." It is *since* that time that "ophthalmology has been raised from a mere appendage to medicine and surgery to the rank of an independent science." It is *since* that time that Soelberg Wells offers an apology for a new "*English* Treatise on the Diseases of the Eye," "the want of a work which should embrace the *modern doctrines* and *practices* of British and foreign schools of ophthalmology, and should thus *enable* the practitioner and student to keep up with the *knowledge* and *opinions* of the *present day.*" It is *since* that time that "*certain forms* of *amblyopia*" that sorely puzzled the oculist, and were by him too often deemed incurable, and "set all remedies at defiance," have been *discovered to be in* "*reality dependent* upon some *anomaly* of the *refraction* of the eye, or peculiar assymmetry of the organ,"

and have "been found to be *amenable to treatment.*" It is since that time that it has been "definitely settled that the necessary change in the refraction of the eye during accommodation is due to an alteration in the form of the crystalline lens;" and that there "can be *no doubt now* that this change is *entirely* due to the *action* of the ciliary muscle;" and that even a "*certain tonicity*" of this muscle "causes its *action* on the *convexity of the lens* to continue while at rest." It is *since* that time, even as late as 1873, that a *reviewer* of a "neat pamphlet of twenty-nine pages" attempted to prove that "it *has not been 'definitely settled* that the ciliary muscle acts on the crystalline lens' so as to *produce* any *effect* in the *accommodation of the eye whatever.*" It is *since* that time that Graefe, "who was *born* thirty-five years after the use of the wire optometer was published to the world by Dr. Young, *invented*, devised, constructed, or caused to be constructed, the wire optometer that bears his name; and that Snellen, who is a "*Dutchman*," devised his test-types. It is *since* that time that Helmholtz, Donders, Graefe, Knapp, Stellwag, Arlt, Jaeger, Hering, and others with scarcely less honored names, have ascended to the pinnacle of fame and sculptured their names high on the rock of ophthalmological science, where they will be read and honored ages hence. It is *since* that time that the writer of an unpretending little pamphlet of twenty-nine pages made "the most *remarkable of the many remarkable statements*," that "for most of our knowledge of the diseases of refraction and accommodation we are indebted to the researches of that wonderful people, the Germans!" And furthermore, he gives a few of the names worthy of all honor, in connection with the subjects on which he was writing, by whose joint labors a new science has in less than a quarter of a century been built up. He mentions Helmholtz, Donders, Graefe, Knapp, Arlt, Stellwag, Jaeger, Hering, and their fellow co-laborers (among whom he might with great propriety have added the names of such men as Wecker, Lieb-

reich, Laurence, Bowman, and "*Snellen, who is not a German, but a Dutchman, living in and writing at Utrecht, in Holland.*" I give the beginning and the ending of his history.

"The subjects treated of in the pamphlet under review are Refraction and Accommodation, Myopia, Hypermetropia, Presbyopia, Astigmatism, and Asthenopia. . . . We believe we have thus shown that all the matters treated of by Dr. Fenner were known to the profession more than 'a quarter of a century ago;' and that the Germans had nothing to do with their discovery, *except* in the single instance of the *ophthalmoscope*, by Helmholtz, in 1851."

Here we have the announcement that "the *subjects* treated of in the pamphlet under review are refraction and accommodation, myopia, hypermetropia, presbyopia, astigmatism, and asthenopia;" "and that the Germans had nothing *to do with their discovery* EXCEPT" the ophthalmoscope, which has not been "treated of by Dr. Fenner," either in the paper under review or in any other paper. Surely this winding-up sentence would lead us to suspect the *nationality* of the reviewer. Germans and Dutchmen seldom construct such sentences.

Here again we have the announcement of the *discovery of the ophthalmoscope* by Helmholtz. Query: in what age of the world was that ophthalmoscope invented and constructed that Helmholtz *discovered* in 1851.

In deference to the peculiar sensitiveness of my friend, Dr. Reynolds, as to the honors belonging to the *Dutch*, should a second edition of my little treatise be called for I will insert the word Dutchmen after Germans. C. S. F.

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**Transactions of the Kentucky State Medical Society,** Eighteenth Annual Session, 1873.

This is a handsome little volume of one hundred and sixty-eight pages. Instead of the prolonged bitter ethical squabbles that have so frequently disgraced the meetings of

medical societies, the present volume of Transactions shows a most healthy state of affairs in our state society. While there are some things in this volume with which we might find fault, there is upon the whole much to praise; in fact, we are proud of the society for the first time in many years. The last meeting was devoted almost entirely to the consideration of scientific subjects, and what we are especially inclined to praise, the earnest discussion of practical medicine by the members in open session. The subject of discussion being *cerebro-spinal meningitis* elicited some important facts concerning the pathology and treatment of the disease as observed by different members in their respective localities during the late epidemic.

Passing over the able and gracefully-written address of the president, which has already appeared in this journal, and an elaborate paper, by Dr. E. Richardson, denouncing the present system of medical education, we find "History in Disease," a spirited paper, by Dr. J. J. Speed. In April, 1859, Dr. S. wrote: "The great need of the American people is a race of doctors who have the courage to tell them plainly, TAKE LESS PHYSIC. For generations the habit from babyhood up to the lean and slippered pantaloon has been to medicate for every conceivable ailment." . . . . He adds in the present paper: "The conviction of that day is deepened and confirmed by the added experience of fourteen years." Dr. Speed justly complains of "the disastrous reign of polypharmacy," and yet the past decade has witnessed a most decided improvement in this respect.

The "Report on Finance," by Dr. Joseph Smith, of Lexington, is brief, well written, and contains some very pertinent remarks in relation to the scientific as well as the financial welfare of the society.

"Obstetric Procedures among certain of the Aborigines of North America" is the title of a very carefully-prepared and entertaining paper by E. McClelland, M. D., Assistant

Surgeon U. S. A., copious extracts from which appear in the "Clinic of the Month."

The "Report on Surgery," by Dr. J. W. Thompson, evinces that painstaking labor for which the author is becoming so distinguished.

Dr. D. T. Smith's "Report on Vital Statistics" embraces also the subject of moral philosophy, political economy, etc., and winds up by informing the reader that, "in view of the direction and rapid strides of the present day, it is no strained conclusion that society's statistics will soon become the basis of the social conscience."

The "Report on Registration," by Dr. S. A. Foss, contains some practical suggestions, which have already been acted upon by the society with every prospect of early success. This registration-law question has been discussed without avail, until now, for nearly ten years. Committees have gone almost annually to Frankfort, and returned as they went; but Dr. F., in a brief, well-written, common-sense paragraph or two, has solved the problem, and next winter a petition will be taken to the legislature, by nearly every member of both houses, asking the passage of a suitable registration law.

A paper, by Dr. R. C. Brandeis, on the Laryngoscope, though it occupies but nine pages of the Transactions, brings this most interesting subject fully down to the very latest word.

An article on the therapeutic properties of electricity, translated from the German by Dr. B. Tauber, of Paducah, while it possesses but little intrinsic interest, shows the translator to be capable of doing such work uncommonly well.

Major Bidwell's response to the toast "Law and Medicine" embodies some very beautiful sentiments, which the publishing committee very wisely preserved and published. Major B. is a scholar, and we feel assured that all who read his remarks will agree with us in the opinion that, had he pursued it, he would have reached the same eminence in medicine

which he has so justly attained in his chosen profession of the law.

Memoirs of Drs. J. Taylor Bradford and Hugh Rodman, late members of this society, by Dr. Lunsford P. Yandell, form the last article in the volume. A very inaccurate list of the names of members concludes it. Upon the whole, however, the secretary and the publishing committee deserve the thanks of the society and the profession for the very prompt and faithful discharge of their duties. D. S. R.

# Clinic of the Month.

OBSTETRIC PROCEDURES AMONG THE ABORIGINES OF NORTH AMERICA. — Dr. Eli McClellan, Assistant Surgeon U. S. A., read at the late meeting of the Kentucky Medical Society a paper on this subject, full of interesting facts and experiences, which we had hoped to publish in full, but our space limits us to a few extracts.

"Among the better classes promiscuous sexual intercourse, as far as the unmarried are concerned, is almost entirely unknown. While parents upon one hand expose their children to imaginative excitation, they guard their persons with considerable care. Except in the larger towns, defiant prostitution is unknown. Menstruation is established between the thirteenth and fifteenth year among those who constitute the better class; but among the lowest — those in whose lives scenes are constantly being enacted which rival in iniquity those reported by Cobden or Mayhew, or, lacking the refinements of vice, equal those of Constantinople or other Mahommedan cities—it occurs from one to two years earlier. Among such people additional arguments may be found to favor the theory 'that precocious menstrution' *is* influenced more by licentious practices than climatic influences or hereditary peculiarity. Nor in this case can the argument against such theory be advanced 'that the utter depravity and promiscuous cohabitation of the lowest English peasantry and the lewdest classes in such cities as London, Liverpool, Manchester, and Birmingham does not induce precocious menstruation.' It must be borne in mind that female children in such condition are both underfed and overworked, while

L. of C.

among the New Mexicans the children lead an idle life, with naught to distract them from their natural inclinations; that at an early age they become addicted to the use of tobacco; and that chile or pepper, green or dried, is an invariable condiment of all meals, and used to an excess that rivals the Indian use of curry. Marriages occur at an early age, often before the menstrual functions have been established. Subjected thus early to the incidents of matrimony, the early menstrual months are periods of irregularity and suffering. Diseases of the uterus and its appendages are developed at an early period. More than one instance came to my knowledge in which ovulation was followed by impregnation, but the wife never menstruated until one or more children had been born.

"The disorders to which these females are liable can in part be attributed to the neglect of hygienic laws and the indolent life which they lead. The surface of the body is rarely protected, save by a chemise, shirt, and shawl. Undergarments are almost unknown. The extreme altitude of the territories occupied by their race, the sudden and great variations of temperature to which they are exposed, are fruitful sources of uterine diseases, while the peculiar domestic relation and the stimulating diet which have already been noted, combined with the erotic imaginations of indolent vice, cooperate. 'To excite, but always in vain, is to provoke disease, irritate the body, and desiccate the soul.' Abortions are rarely procured; sexual frauds (so-called) are never attempted; infanticide is almost unknown. Masturbation prevails to some extent among both sexes.

"Promiscuous sexual intercourse among the unmarried of the Apache Indians is common. They are polygamists. The women are unclean and debased. The Navajoes, a branch of the Apache tribe, live in the rudest huts and lead a drunken, worthless life. The women are debased and prostituted to the vilest purposes. Syphilitic diseases abound. Polygamy

exists among the Utes also. Their females are rigidly secluded from strangers, and they compare most favorably with those of the other tribes. In these tribes menstruation is established at from the fourteenth to the sixteenth year. Menstrual disorders are common, but they seldom reach the eye of intelligence. Menstrual superstitions abound. At this period the woman is 'unclean;' 'she must not remain in camp, but must live apart.' They are married young, without reference to menstruation; pregnancies are delayed, and families rarely contain over three children. Twins, triplets, or monstrosities are almost unknown.

"Among Indians pregnancy and parturition are fraught with the same dangers as they are to civilized women, although the exposed lives they lead prepare them to brave and overcome perils to which delicate women succumb. That easy and unassisted labors occur there is no attempt to deny. Indian women do step out from the line of march into the brush and at night come into camp with a new-born child. Authentic instances are in our possession of delivery being effected in strange positions and under curious surroundings. One in which a Blackfoot woman, taken in labor at a frontier house, went out of doors to a sheltered position on a snow-bank, there delivered herself of the child, and returned to the house; another, of an Osage, who was taken in labor while on horseback and on the march; she delivered herself and dressed the baby, although her pony never left the trail; but it must be known that she was riding upon a large, broad pack, upon which she could recline. These cases, however, for heroism do not compare with the young woman whose case is related by Dr. Bassett, who unassisted performed the cesarian section upon herself while lying upon a snow-drift.

"To the Mexican female parturition is attended with greater danger than it is to those of more civilized races, on account of the extraordinary manipulations to which they are subjected by their attendants. The fact has already been noted

that in the house inhabited by them the rafters are invariably uncovered. In commencing housekeeping their arrangements would be incomplete without two strong iron hooks, which are driven into said rafters about two and a half or three feet apart. The location selected is generally a little off the center of the roof and toward the fire-place and chimney, said hooks being destined to play an important part in the obstetric history of the family. The patient having declared the occurrence of labor-pains, all the near friends of the family are summoned, male as well as female. Two stout ropes are secured to the aforementioned hooks, the floor beneath them is covered with undressed sheep-skins, and upon these the patient kneels, with her thighs widely separated, her body maintained in its upright posture by the aid of the ropes. A male, selected on account of his strength, and to whom the term 'el tenador' (the one who holds) is applied, now places himself on the floor behind the patient, encircles her waist with his arms so that her buttocks rest upon his abdomen, and commences a steady, constant, and oftentimes violent pressure upon the uterine tumor. The midwife stations herself upon the floor, but in front of the patient. Her duty now is to knead, and, if too long a period occurs between the pains, to seize the abdomen with both hands and execute a series of spasmodic jerks. When not thus employed she constantly manipulates in order to soften the genitalia. In this position and thus assisted the patient is kept until nature, assisted by the strength and awkwardness of the attendants, effects the delivery, or they become convinced that some other procedure must be resorted to. During all this time 'el tenador' keeps up his pressure, increased when the pain comes on, and if possible never relaxed, so that the advance gained may not be lost. No care is taken of the perinæum, nor does the idea occur to them that this may be necessary; they expect it to 'rip,' and if an unusual laceration occurs the patient suffers in silence.

"The child having been delivered, the patient is placed upon her back and allowed to rest for a time. If the placenta be not expelled, they proceed to effect its delivery by strongly compressing the abdominal walls, by traction on the funis, and by shifting the patient from one side to the other. When successful the woman is placed upon her bed with unchanged clothing, a long, narrow woolen band is wrapped many times around her abdomen, her head is bound with linen cloths, and she is ready to receive the congratulations of her friends. As to the child, a rather curious custom prevails as to the treatment of the cord. It is cut from three and one half to four inches in length, a stout ligature is applied about one inch and a half from the umbilicus, when the midwife with a brand of fire proceeds to char and roast all that portion beyond the ligature. Many superstitions exist by which different communities are influenced as regards the treatment of the cord. All unite in affirming the necessity of adopting measures which will prevent the cord from ascending within the maternal abdomen, thus becoming lost; and once lost the only guide to the 'after-birth' is gone. Some midwives will not sever the cord until the placenta is extracted; others make bold to do so, but always adopt the precaution of attaching the placental extremity by a stout cord to the thigh of the patient. So much for cases in which nature asserts her power and delivers the unhappy woman from her tormentors.

"In cases where much delay occurs, or where after the labor has progressed a considerable time the midwife can not feel the descending head, although profoundly ignorant of presentations and positions, she announces that some other procedure must be resorted to. Before adopting the more complicated of their devices they endeavor to soften the parts by applications of steam and smoke. To accomplish this a basin is filled with glowing embers, upon which is sprinkled a powdered aromatic root, the basin is placed between the thighs of the kneeling woman, and its exhibition is continued

from twenty to thirty minutes; or a large vessel of water in which is placed certain herbs is caused to boil and the vapor to arise to the person of the patient. These simple means being ineffectual, the patient is caused to stand upright, when, several of the strongest persons present taking her by the shoulders and knees, she is violently shaken, which exercise is closed by a series of short, sharp, wrenching jerks. She is then placed again in the 'ropes,' and the squeezing process is resumed. Being still unable to deliver the child, the operation is repeated; and if still unsuccessful it is varied by suspending the patient head downward, her person being held as in the preceding maneuver. Should these efforts be still unsuccessful, the midwife announces that it is necessary to change the position of the child. She proceeds to remove all articles of clothing from the lower portion of the patient's person. A long, shallow wooden bowl is placed over her abdomen and turned quickly from right to left with a grinding motion. Should this still prove ineffectual, a horseman is dispatched for the nearest American doctor, a rosary is placed about the patient's neck, and all present join in commending her to the saints. San Ramon or La Niña (the Virgin) are the most powerful to whom recourse can now be had; and as the doctor often lives fifty, sixty, or more miles away, ample time is afforded for their intervention. If one will not help, in spite of candles or other offerings, the other will surely take advantage of his or her colleague, and lend his or her most efficient aid. But saints, even the best, seem at times disinclined to aid humanity, or they may be too much occupied with other affairs, when the only recourse the poor mortals can have is to discover the particular saint on duty at that particular time. A large candle is notched with the thumb-nail to ten, fifteen, or more equal spaces; each space is designated by the name of some saint; the candle is lighted, and as soon as it burns down to the allotted portion of the then inclined saint he will help right willingly, and try his

best to effect delivery before his short time melts away. But with the passing light of the candle wanes the strength and life of the poor patient, buffeted and distressed, rent by useless, senseless torture; and not unfrequently she passes to her final rest with a smile at last upon her tired, weary face, while the earnest, anxious doctor is galloping weary miles, trusting he may yet be in time to afford her some relief.

"The description which has been given is the modern practice of obstetrics among these people. Until quite recently the obstetric chair or stool was in vogue among them. Of what the ancient stool consisted we have been unable to learn; the modern was a large chair, in which '*el tenador*' first seated himself; then the patient squatted upon his knees, with the inevitable arm and rope accompaniment. The obstetric customs of the Pueblo Indians closely follows that of the Mexicans, if they are not in all points identical. The Apache woman when labor commences is placed in a small hut and left to herself. Should her band be upon the move, sufficient food is left with her, and she is abandoned to her fate. If the labor terminates favorably, as it most always does, she regains her party. But instances are known in which scouts through the country infested by these Indians have discovered the remains of mother and child in these isolated huts. The Navajoes have adopted many of the customs of the Mexicans. A fatal termination of labor is rare. The parturient female assumes the posture of the Mexican in similar cases, and is supported by a lariat thrown over a limb of a tree, or she supports herself from a low branch. But the assistant is now in front, and aids the woman during pains by a finger inserted at the umbilicus, from which point pressure is made steadily upon the fundus uteri. The Ute female in summer accomplishes her labor in the open air, squatting or kneeling by a tree which they may conveniently grasp. They are assisted by a band passed around their abdomen, and which is managed by an old woman. Lingering labors are

treated as by the Mexicans, with the exception of rapid and violent changes of position, the patient being suspended in a blanket or robe.

"A friend, who has acquired a considerable obstetric experience among their people, remarks: 'It is surprising with how little difficulty girls of fourteen or fifteen years of age are delivered in childbirth. It is by no means an unusual occurrence for a labor to be terminated in six or less hours, and the only difficulty experienced is in persuading them to remain recumbent a sufficient time.' Hemorrhagic labors are frequent. The American physician is most frequently called from that cause; and also to deliver the placenta. Nor is it surprising that inertia or irregular contractions should succeed the treatment to which the patient has been subjected. Thrombi of the labia and vulva are frequently met with, while ruptures of the uterus, situated fortunately most frequently at the cervix, are by no means rare. Two cases of fracture of the ribs from the violence of attendants came under our notice. For retained placenta the midwife has no remedy save binding a cord around the abdomen of the patient, and this, with an occasional dose of a powder obtained by burning the ears of a freshly-killed hare, is the only means at her command for arresting hemorrhage. Tradition, in the settlement of Socorra, points to an old woman who was taught by a Padrê to take the after-birth by the hand, but she was probably a myth. At all events she has left no successor."

EXCERPTA FROM GERMAN PHARMACEUTIC JOURNALS by Mr. C. Lewis Diehl, Professor of Theory and Practice of Pharmacy in the Louisville College of Pharmacy.

*Chlorine-water*—According to Mylius chlorine-water is best administered with syrupus simplex, by which it is also conserved better than with honey, glycerine, or syrupus althaæ. Mucilage of gum will also answer well. The author

finds that chlorine-water without such addition will give off its chlorine much more rapidly.

*Opium culture in Germany*—Mr. Julius Jobst states that the cultivation of the poppy for its opium is carried on to an important extent in Wurtemberg, and that the quality of the opium yielded is superior to the oriental product, containing from twelve to fifteen per cent. of morphia. During a tour in Asia Minor, in the winter of 1871, he became convinced that the climate of Wurtemberg is in every respect as well suited to the culture of opium as is that of Asia Minor, where, for example, it is regarded as a necessary condition to a good opium crop "*that the poppy-field should be covered with snow during several months.*" Jobst secured a quantity of poppy-seeds from the district producing one of the most valuable varieties—Boghaditsch opium—with which he has made comparative experiments with the following results: The oriental poppy-plant is of a lighter color than the indigenous poppy, has dark, violet-colored flowers, remarkably few leaves, and reached a height of two feet; the capsules are small, but well filled with extremely small bluish seeds. Owing to its small growth it is not exposed to the same extent to the influence of storms as is the taller indigenous variety, and it ripens several weeks earlier. The oriental variety yielded a little less opium than the indigenous variety, but the morphia strength of the two opiums is nearly the same—opium from oriental seed containing 12.6 per cent. morphia, 0.12 per cent. codeia; opium from indigenous seed containing 12.8 per cent. morphia, 0.09 per cent. codeia. The author states that in the neighborhood of Saarau and Bohrau, Silesia, opium has been cultivated which yielded thirteen to fourteen per cent. morphia, three to four per cent. more than oriental opium yields.

From the report of the Chamber of Commerce of Breslau, 1872, it appears that the experiments upon opium culture have been discontinued in Silesia, as it has become evident that, while the cultivation of the poppy for its seeds is very

remunerative, its cultivation for its opium is unprofitable. The yield of opium is small, and its collection causes a diminution of the seeds.

But this does not agree with the experiments of Julius Schrader, who has found that the annual yield from capsules from which opium had been collected was the same as from capsules which had remained intact. The opium obtained was a fair yield, and contained eleven per cent. of morphia. There was no difference in the yield of fixed oil from the seeds as obtained from the two sources.

*Carbolic acid*—In the course of his investigations upon the value of carbolic acid as a disinfecting agent, P. C. Plugge also studied its power as a reducing agent, and discovered incidentally that nitrate of protoxide of mercury containing traces of nitrous acid served as a delicate test for its presence. When a solution of such a salt is boiled with a solution containing carbolic acid a reduction of mercury occurs, and the liquid assumes sooner or later, according to its dilution, an intense red color. The reaction is distinct in one sixty-thousandth dilution, and is manifest even when the dilution is one two-hundred-thousandth.

*Alcohol from lichens*—The production of alcohol from lichens assumes gradually the character of a regular industrial pursuit in northern Finland, Russia. The quality of the spirit gives eminent satisfaction, and its manufacture from the above source—first practiced in Sweden—should be encouraged, as thereby the cereals will find more legitimate use in countries where they are often very scarce.

*Gum tragacanth*—According to J. M. Stöckel the gum tragacanth exported from Smyrna is collected from the plant growing upon high mountains in the interior of Asia Minor. It is most abundant in the neighborhoods of Caraïssar, Yalovaschi, Burdur, Musul, and Karaman. The gum is collected partly naturally exuded and partly by incision. If it is allowed to remain upon the plant too long it becomes dark,

hard, and knotty, instead of flaky and white. The best gum is collected in the neighborhood of Yalovaschi and Burdur, the collections continuing until the rainy season sets in, which occurs usually in September. When this occurs earlier it becomes necessary to house the crop as rapidly as possible, and this sometimes causes the crop to be more or less inferior than those of other years.

*Olive-oil*—It has been observed that rich harvests of olive-oil occur with tolerable regularity every third year in the countries supplying the Smyrna export markets. The oil growing in the interior of Asia Minor, which is of a very handsome deep-yellow color, is said to be inferior to that grown near the coast, which is greenish in color. The expression of the oil is still conducted in very rudely constructed wooden presses, which J. M. Stöckel thinks would be advantageously supplanted by the iron presses in use in Italy and Spain, from which the oil flows purer and requires less time to clarify.

*Pills of protoxide of iron*, when prepared by the formula proposed ten years ago by W. Kirchmann, keep perfectly. 8.0 grm. crystallized sulphate of iron and 1.3 grm. calcined magnesia are intimately mixed and formed into sixty pills by the aid of sixteen drops of glycerine. They are readily coated with sugar, and are readily soluble in water, leaving a magma of protoxide of iron. As sulphate of iron and sulphate of magnesia require the same amount of water of crystallization the pills form with the glycerine a very handsome mass, which also prevents the efflorescence of the sulphate of magnesia formed; while the latter, covering the protoxide of iron intimately, prevents its oxidation for years.

*False belladonna*—Herbalists of Madrid have offered for sale and sold for belladonna a plant which is not belladonna at all, and does not even belong to the solanaceæ. It is called in the Madrid markets "*belladonna silvestre de la casa de campo*," and is botanically the *Cucubalus bacciferus*, Linn.,

abounding in humid situations in European forests, and especially among the underbrush of the casa de campo and other portions of the province of Madrid. Its botanical characters readily distinguish it from the true belladonna.

ERGOT IN THE TREATMENT OF NERVOUS DISEASES.—Dr. Daniel Kitchen, Assistant Physician to the New York State Lunatic Asylum, makes, in the July number of the American Journal of Insanity, an interesting report of the action of ergot in certain nervous affections. He used the fluid extract prepared by Squibb, and the aqueous extract, or ergotine, made by Merck, of Vienna. The dose of the former is from one to two drachms; the latter from six to ten grains. One drachm of the alcoholic extract of Squibb's preparation is equal to about six grains of the ergotine. He also used a few ounces of a solid extract, made by Squibb, which is about equal in strength to imported ergotine. The full physiological effect of ergot will last from one half to three quarters of an hour.

"There is probably no condition so annoying to the patient as headache, and certainly it is the most common. In the following forms we have used ergotine with much benefit and comfort to the patient: 1. Headache, depending on plethora or fullness of blood; 2. Headache from anæmia; 3. Headache, depending on changes in brain substance and the membranes; 4. Epileptic headaches; 5. Migraine; 6. Headache depending on disordered menstruation. The most common form of headache is the first, or that depending on a plethoric condition of the blood-vessels of the brain. Of course we can not estimate correctly the amount of pain endured at each sickness, but it depends largely upon the constitutional character and nervous susceptibility of the patient. In plethoric headaches the course is either very short (a few hours at most), or they last for some days. The pain is usually referable to the back of the head, and there is much throbbing of the temporal arteries. In this class of headaches we have used

ergotine largely; about one hundred patients have been prescribed for, and in almost every instance relief was given in less than half an hour, and the attack thoroughly cut short.

"In headache from an anæmic condition of the brain the blood-vessels are usually lax, and as a consequence there is a slowness of the circulation. Ergotine contracts the blood-vessels, thereby giving tone to the arterial system; the blood is forced more quickly and regularly through the brain, and of course in greater quantity. Our cases of cerebral anæmia are comparatively few, and experiments are therefore limited; yet in those cases where we have had an opportunity of using it happy results have followed. In epileptic headaches and in epilepsy we have used ergot largely. In *petit mal* there are muscular twitchings, congestions of the face, suffusion of the eyes, and a rush of blood to the head. We have in many of these cases been able to ward off the *grand mal* by large doses of ergotine. We have often combined it with conium, and it seems in this combination to work even more satisfactorily than alone, which is chiefly due, we suppose, to the sedative effect of the conium. In migraine, or sick-headache, we have distended blood-vessels pressing on the ophthalmic division of the fifth nerve, thereby causing the pain; and if we accept this theory, then ergotine, by contracting the blood-vessels, will relieve the headache. In headaches depending upon some disordered condition of menstruation we usually have a fullness or congestion of the cerebral vessels; sometimes, however, it may occur from anæmia of the brain. In both forms the use of ergotine is beneficial."

Dr. K. concludes his paper with the following statements: "1. Benefit of combination with bromide of potassium in epilepsy; 2. It is apt to produce cramps and pain in the stomach, which is remedied by combination with conium; 3. In nervous diseases it soothes all renal irritation and catarrh of the bladder; 4. It dilates the pupil sufficiently to be noticed; 5. Increases both frequency and tension of the pulse; 6. Has

no appreciable effect on the heat of the body; 7. In large doses it produces the same effect as conium, by inducing sleep; 8. Its beneficial action in delirium tremens, after bromide of potassium has failed; 9. It combines readily in form of pill with sulphate of quinine; 10. It is a cerebral sedative; 11. Ergotine possesses an advantage over the alcoholic extract in not producing any pain or cramp in the stomach, and is given in smaller quantity; 12. Ergot is not likely to be adulterated, and we always secure an appreciable effect after its administration."

A New Mode of Treating Functional Dyspepsia, Anæmia, and Chlorosis. — We copy the following, by Dr. C. E. Brown-Séquard, from Archives of Scientific and Practical Medicine:

"In 1851 I had to treat a very bad case of dyspepsia, and succeeded in curing the patient by a plan of treatment which, I think, deserves attention. Since that time I have employed it with complete or partial success in a number of cases of dyspepsia, of chlorosis, of anæmia, and also as a means of ameliorating or curing nervous affections caused by gastric disturbances or poverty of blood. I could not say, as I have not kept notes of all the cases, how many times it has succeeded or failed. In a number of instances where failure occurred I have found that the patients had not carefully followed the rules, and that the failure was, at least in a good measure, due to this lack of care. In two cases only some increase of flatulency and acid eructation took place for three or four days, when the plan was given up. In a case of dropsy, attended with anæmia, dyspeptic pains were increased for a week, when the plan was abandoned. These are the only instances I remember in which some bad effect was produced by this plan, and this aggravation soon ceased.

"The first patient I submitted to this plan was a scientific man, thirty-four years old, of strong constitution, but from

several causes reduced to a lamentable state of health. For about eight years he had been working very hard, taking no exercise, and living almost all the time in a vitiated atmosphere. He slept very little, and usually passed eighteen or even nineteen hours a day writing, reading, or experimenting. His diet was miserable, and, with the object of avoiding the need of much food, he took a great deal of coffee. He gradually, though slowly, became exceedingly weak. His digestion, which had been very good all his life before he began to work so much, had gradually become very bad. He suffered greatly from pyrosis, and a feeling of great distress, and gastric distension after each meal. Acid eructations and gas were frequently thrown up into his mouth, and when he did not vomit he found that his food remained on his stomach so long that in the morning he frequently rejected things eaten the previous day. At last he had to give up work and stay in bed. But no improvement occurred from the rest he then had or from various modes of treatment. His emaciation and weakness and dyspeptic symptoms increased, and his friends decided to have him removed to the country. But he was so weak that he had to be carried in a litter to the railway station. After a few days, finding that he had not improved, I decided to try a radical change of his alimentation as regards the quantity of food to be taken at a time. Instead of *three* meals a day I made him take *sixty* or more. Every twelve or fifteen minutes he took two or three mouthfuls of solid food, chiefly meat and bread. He drank a little less than a wine-glass of Bordeaux wine and water every thirty or forty minutes. On the very first day this mode of alimentation was begun his digestive troubles disappeared, and within a week he was so well that he returned to Paris, not, however, to go to work again, as he had been rendered wiser, but to prepare to go to the sea-shore. He continued the same mode of alimentation for about three weeks, and then gradually diminished the number of his homeopathic

meals and increased the amount taken at each of them until in about eight or ten days he came to eat only three times a day, and a full meal at each time. His strength during the first week had become almost as great as it ever had been previous to his illness. Since that time his life has been one of great hardship, which he has borne remarkably well, and dyspepsia has only troubled him in a slight degree rarely and for short periods.

"The plan, as stated in the above case, consists in giving but very little of solid or fluid food or any kind of drink at a time, and to give these things at regular intervals of from ten to twenty or thirty minutes. All sorts of food may be taken in this way, but during the short period when such a trial is made it is obvious that the fancies of patients are to be laid aside, and that nourishing food, such as roasted or broiled meat, and especially beef and mutton, eggs, well-baked bread, and milk, with butter and cheese, and a very moderate quantity of vegetables and fruit, ought to constitute the dietary of the patients we try to relieve. This plan should be pursued two or three weeks, after which the patient should gradually return to the ordinary system of eating three times a day.

"It is hardly possible to give more detailed rules as regards this hygienic mode of treatment. On the one hand, I have found few persons willing or able to follow it fully. On the other hand, many patients, especially those who have no dyspepsia, do not need to take so minute an amount of food at a time. Besides, it is certain that the quantity of food required varies notably in different persons. Prof. John C. Dalton states that the entire amount of food needed by a man in full health and taking free exercise is: of meat, 16 oz. av.; bread, 19 oz.; fat, 3½ oz.; and of water, 52 fl. oz.; *i. e.*, about 2½ lbs. of solid food and rather more than 3 pints of fluid. According to Dr. Edward Smith and other European hygienists the amount of solid food and of water required each day is notably larger than that marked out by

the able American physiologist I have named. My experience with the patients on whom I have tried the plan of feeding above mentioned shows that the amount of solid food required by an adult is nearly always as follows: from twelve to eighteen ounces of cooked meat and from eighteen to twenty-four ounces of bread. As regards the quantity of fluids I have allowed, it has always been notably less than the amount indicated by Dr. Dalton (three pints) and by Dr. E. Smith (four and a half to five pints).

"I hardly need say that in carrying out the plan I propose attention must be paid to three points: first, the liking and the disliking of certain things by the patient; second, the importance of variety in food; third, the digestibility of certain things compared with others, digestibility which varies immensely in different patients. When I found that there was no disgust for a meat-and-bread diet I ordered that roasted beef or mutton, with bread, be the almost only kinds of solid food taken. But most patients were either soon disgusted with this diet or refused even to try it. Having ascertained this, I allowed the selection by each patient of his own dietary, insisting, however, that the quantity of cooked meat should be at least twelve ounces a day. The most varied diet as regards the kind of food can be followed, however, under this plan as well as when one has only two or three meals a day. The only absolutely essential points are that the amount of food taken every ten, fifteen, twenty, or thirty minutes be very small (from two to four mouthfuls), and that the quantity of solid food in a day be from thirty-two to forty ounces, or a little less when, instead of water, the patient drinks beef-tea or milk.

"I will not enter into long explanations to show how a marked benefit or a cure can be obtained in functional dyspepsia, in anæmia, and other affections by this mode of alimentation. I will simply say that the facts I have observed agree with the view that we are naturally organized, like most

if not all animals, to eat very frequently, and not, as we do, two, three, or four times a day. It seems certain from the facts I have observed that functional dyspepsia, when once it has begun (never mind by what cause), is kept up and increased by distention of the walls of the stomach. This fact is already well known, and physicians generally recommend that the quantity of liquid taken be very small, and that the solid food be as nourishing as possible, so that its bulk may be reduced, with the view of avoiding great dilatation by the fluid and solid substances introduced in the gastric pouch. But, although deriving some benefit from this diminution of distension, many patients continue to suffer who might be benefited or cured by the plan I propose.

"It may be asked if there is no danger that distension of the stomach by a full ordinary meal, after a patient has followed for two, three, or four weeks the plan I propose, would not be more difficult and a source of greater trouble than before that organ had been allowed to contract considerably during the time this plan has been pursued. Facts answer this question in a way that leaves no doubt. There has never been in the cases I have attended the least trace of an increased trouble due to that cause. Even those patients who have not derived benefit from my plan of alimentation, and among them two who had while following it more acidity and flatulency, have at any rate had no increased trouble after having given it up. It is probable that the good obtained from this plan in dyspeptic patients depends at first on the rest given to the irritated stomach, and subsequently on a great amelioration in the quality of the gastric juice.

"In anæmia and chlorosis, not complicated with dyspepsia, the advantage of this plan lies in the rapidity of the formation of blood from the notably increased amount of food that the patient can digest.

"I have made but very few trials—and incomplete ones—of this plan in cases of organic affections of the stomach. I

can not but think, however, that it deserves being tried in most of such cases.

"Against the obstinate vomiting of pregnancy this plan has already been employed successfully by a number of physicians, and once by myself in a case in which many modes of medical treatment had failed."

THERAPEUTIC SUMMARY FROM THE RAVISTA CLINICA DE BOLOGNA.—*Carbolic Acid* has been praised in prurigo and pruritus, subcutaneously injected in doses of about one centigramme of the acid mingled with water. It has been used externally in acute articular rheumatism as a liniment mingled with linseed-oil. *Arsenic* has been recently recommended in cases of strumous enlarged glands of the neck, and also in pellagra. Inhalations of *Bromine* have been used in croup and diphtheritis; thirty centigrammes of bromine, thirty of bromide of potassium, and one hundred and fifty grammes of water are combined in a lotion, and a sponge imbibed with this fluid is placed before the patient's mouth for five or ten minutes every hour. *Bromide of Iron* is employed by some in cases of spermatorrhœa and involuntary seminal emissions, in doses of fifteen to twenty-five centigrammes occasionally, and, before the patient goes to sleep, in a dose of fifty centigrammes. *Bromide of Potassium* has recently been used in cases of the sickness of pregnancy and in cases of leucorrhœa, effecting cure in less than two months in the latter case. It is useful in summer diarrhea in infants, in doses of three centigrammes every two hours. *Bromide of Sodium* has a similar efficacy to that of bromide of potassium in epilepsy, and proved a cure in one case of tetanus. *Coffee* has been given in infusion in cases of infantile typhus fever. *Conium* has been used successfully in cases of mania, accompanied by muscular agitation. It acts on the motor center, sparing the sensory tracts. Of twenty-five patients treated by this substance twenty-two times the muscular agitation

subsided. *Hydrate of Chloral* has been used in cases of nocturnal incontinence. *Chloride of Potassium* has been used instead of bromide in epilepsy, and it is asserted to be more efficacious; dose, 3.50 to 5 grammes a day. *Copaiba* has been recommended in certain cases of psoriasis. *Iodine* has been recommended in cases of nocturnal incontinence of the aged; one drop of the tincture every hour in water. The tincture has also been recommended in intermittent fever, in doses of ten drops, thrice daily. *Iodoform* is used in chronic venereal ulcers, and much praised as an antiseptic. *Iodide of Silver* is recommended in hooping-cough. *Koussine* is an excellent vermifuge, and is given in the morning in doses of 1.25 grammes in a little syrup. *Phosphorus* has been recommended in chronic skin diseases, in oil, or gelatine capsules, containing each from two to six milligrammes of phosphorus, in oil. Acne indurata, lupus, psoriasis, and scrofulous skin diseases have been cured by such means. (The Doctor.)

The Treatment of Anasarca, Ascites, and obstinate Pleuritic Effusions by Milk.—MM. Sirédey and Cordier *(Journal de Médecine et de Chirurgie Pratiques)* have used this old and rather favorite remedy against dropsies in a way which they consider renders it less troublesome and repugnant than the "milk-cure" is otherwise apt to be. At the same time that Sirédey prescribes two pints of milk a day to his patients he allows other kinds of food and drink. Cordier, in his thesis, cites cases of albuminuric dropsy in which the diuresis was rapid and considerable, and the dropsy disappeared under this treatment. The diet is otherwise moderate, including meat and a little wine. He does not give more than two or two and a half pints of milk, at convenient intervals, in the day. He prefers asses' milk.

# Notes and Queries.

CHOLERA.—The first account of cholera that reached us from New Orleans a few months ago favored the idea of the domestic origin of the pestilence. The disease at last had seemed to spring up there *de novo*, and was not imported. But it is now confidently affirmed that two or three ships had arrived before the irruption of the epidemic from Russia and Rio Janeiro, by which the poison may have been introduced, and so doubt is thrown upon its origin in the city. That cholera may be developed out of Asia, however, is an opinion entertained by many of our ablest etiologists; and having once been brought to our shores, it is certainly quite possible that the germs or miasm engendering it may become naturalized and give rise to periodical outbreaks of the epidemic. A paper, by Dr. Estrazulas, in the American Journal of Medical Science for July, renders it highly probable that cholera arose in South America a few years ago independently of importation. That writer shows that the disease was not known in Paraguay or La Plata previous to 1866, when it broke out as an epidemic; that no case occurred before the armies camped there, and that the pestilence vanished with the removal of the troops; that the Paraguayan army, where the disease first appeared, was secluded from the rest of the world, and completely blockaded by land and water; and finally that no vessels from infected ports arrived at Paraguay or La Plata previous to 1866. But the point can not yet be regarded as settled, and dogmatic assertion is quite out of place where so many facts may be cited on both sides of the

question. The steps of cholera are eminently stealthy, and its poison may exist and be carried about in fomites where there is no reason to suspect its existence. All know how difficult it is in many cases to account for the origin of small-pox, and yet no one doubts that this disease is always dependent upon the specific virus.

However cholera may have originated at New Orleans, its course after it appeared was that which it has uniformly taken, and which has given so much strength to the belief that it is a portable disease; that it follows the lines of human travel, and is carried about by men. It proceeded slowly up the Mississippi to Memphis, and then fell upon Nashville, whence it was radiated to many towns in Tennessee, Kentucky, and Alabama, along the river and the railroads. Nashville, as in all former visitations of the epidemic, suffered severely; no other city in the country up to this time has been visited by the pestilence in so aggravated a form. It is computed that a thousand have fallen victims to it in Nashville and in the county of Davidson during its prevalence. The mortality has also been great in Gallatin and at various points in Sumner County. One hundred and nine are reported to have died in the town and one hundred and forty in the county.

Following the railroad into Kentucky, it has prevailed successively in Franklin, Bowling Green, and Elizabethtown. In Franklin and the surrounding country the deaths before the disease subsided amounted to forty-seven. Proceeding east and south from Nashville it fell upon Lebanon, where it had evinced great malignity in its former visitations, and carried off thirty-four people, chiefly negroes. At Murfreesboro the number of deaths has been fifteen, nearly all negroes. It spread to Shelbyville, Huntsville, Chattanooga, and Birmingham, along the railways; and at the latter place, a town of recent origin and very rapid growth in Alabama, its ravages have been unusually severe. The pestilence has for the

first time, we believe, penetrated into the mountains of East Tennessee, and prevailed with a good deal of fatality at Greenville, a few fatal cases having also occurred at Knoxville and some other points.

The towns in Kentucky on the Ohio have not escaped, and Paducah and Henderson have lost a number of their inhabitants, negroes, as every where else, being the greatest sufferers. Mt. Vernon, in Indiana, has been severely scourged. This is a cleanly town on the Ohio, and has one of the most elevated sites on the river between Evansville and Cairo. Nothing in its situation or sanitary aspect would have pointed it out as a place likely to invite the disease, and yet forty deaths occurred there in one week from cholera, while Cairo and Evansville were almost if not quite exempt from it.

Cases of cholera have been announced in various places north of Kentucky, as well as in some of the towns in the center and north-eastern parts of the state. The boat which brought the first cases up the river from New Orleans landed cholera patients at Cincinnati, and there have been almost daily reports of deaths from the disease in that city for two months past; but the extent of the epidemic has never been alarming, if indeed it is correct to speak of it as an epidemic where only a few deaths a day have resulted from it in a population of two hundred thousand. In the Ohio penitentiary, at Columbus, a number of the convicts have died from the disease. At Carthage, in Ohio, six deaths from cholera were reported on the 18th of July as having taken place in forty-eight hours. Union City, Tenn., on the Mobile & Mississippi Railroad, has experienced a sharp visitation of the pestilence; but it has nowhere assumed a more malignant type than at Louisiana, in Missouri, where eight deaths are reported as having occurred in four hours. It seems to have been scarcely less virulent at Prairieville and Troy, in the same state; but in all of these places its stay seems to have been very short.

The localizing or secondary causes of the epidemic have seldom been more strikingly exhibited any where than at Nashville during the late visitation. When it was raging with such mortality along the creek bottoms the elevated, best-ventilated quarters of the city were comparatively healthy. It is correct to say that the scourge was nearly confined to the outskirts and lower portions of the city. Edgefield, on the north bank of the Cumberland River, opposite Nashville, standing on a low, sandy plain, with wide, well-ventilated streets, and supplied with good cistern-water, reports less than twenty deaths from the epidemic.

The remark made by us a month ago in respect to the cholera now prevailing continues to be true: the disease shows little tendency to assume an epidemic form. In no city but Nashville, and in only a few smaller towns, has it exhibited that character; for although it lingered long in Memphis, and carried off many victims while it prevailed, it was hardly regarded by the citizens or the profession at any time as an epidemic. St. Louis has suffered but little from it. One week, in a mortuary list of two hundred and forty, not a case of cholera was included, and in a subsequent week only fourteen deaths were set down to that disease. In Cincinnati, as far as we are informed, the greatest mortality from the disease any day has been fourteen, and it is said to be declining there as at all the points where it has broken out. It has been the good fortune of Louisville again to escape the pestilence. A number of cases have been brought here, but the disease has not been propagated. Dr. Palmer reports two cases in another department of the Practitioner, and a third case followed close upon the heels of his second, in the same neighborhood; but since that time no new cases have been reported in the city.

The disease, at the same time, has exhibited generally its characteristic virulence wherever it has broken out. Thus at Cincinnati, where the cases have been few in proportion to

the population, death in one instance is related to have followed the attack in an hour, and in not a few cases it took place in five, six, or seven hours. In one hundred and sixteen cases it ran its fatal course in less than twenty-four hours, and in twenty-five others ended in death in from twenty-four to forty-eight hours. In Louisville two or three of the few fatal cases had a duration of less than twelve hours. The first cases every where have been the most fatal, as has been remarked heretofore of cholera; for the reason, first, that the disease is most virulent at the beginning, and secondly, because the first cases excite no alarm and reach a fatal point before remedies are resorted to. After a time it grows less malignant, and people, being on their guard, attend to the earliest manifestations of the complaint.

It continues to be the uniform testimony of physicians that when the first symptoms are met with appropriate remedies cholera is altogether manageable, and hence the people are urged when the epidemic is imminent to provide themselves with an opiate, in some form, to be taken at once on the occurrence of diarrhea, before medical assistance can be secured. There can hardly be a doubt that the disproportionate mortality of the black population at all the points where cholera has prevailed this season is due largely to the fact that those ignorant people seldom apply to a physician until seized with cramps, when collapse is too often just at hand. They are not alarmed by the painless diarrhea, which in some instances precedes the more violent symptoms a day or two, and generally long enough for the effectual use of remedies if taken at this stage of the disorder.

We have not been able to find any thing new in regard to the treatment of cholera. The hypodermic use of atropia, which was resorted to in India long ago, and was repeated in St. Louis in 1866, has again been suggested, and it has also been proposed to introduce strychnine into the system by the

same method in cases of collapse. For the rest, the utmost diversity of opinion prevails among practitioners. But nearly all are agreed that the disease can be averted if taken early, and that little can be done at a later stage. A singular confusion of ideas is exhibited by some with respect to the action of opium in cholera. In the premonitory diarrhea no other drug is so efficacious. In collapse it is nugatory, as are all other medicinal agents, and its use, if administered freely then, is attended with this danger—that, should reaction occur and the absorbents again become active, it may be taken into the circulation and give rise to fatal coma.

In regard to the efficacy of prophylactic measures in averting the epidemic, physicians are by no means agreed. Such cases as that of Mount Vernon are not easily reconciled with the theory that the disease only prevails where invited by filth, bad water, and insufficient ventilation. The learned editor of the Nashville Journal of Medicine is confident that the disease attacks none who abstain from fruits, vegetables, and animal products. His readers are promised a full exposition of his views and experience on the subject, which will be looked for with interest. If he can establish the dependence of cholera upon diet, he will do much to disarm the disease of its terrors.

It is pleasant to record that the profession every where has done its duty in the season of danger and alarm through which it has been passing in all but one instance—one doctor is said to have run away from Mount Vernon and left his patients when the epidemic was at its worst.

After the foregoing was in type the mortuary report of Louisville for the week ending July 26th announced two fatal cases of cholera, one originating in the city, the other contracted at Elizabethtown. The epidemic has also broken out at Lagrange, on the Lexington Railroad; but almost every where in this country and in Western Europe it is reported to be declining.

An Eloquent Tribute to the Country Doctor.—Dr. McClellan, in his most interesting paper, copious extracts from which we have made elsewhere, pays the following deserved tribute to the frontier doctor: "Of all our professional brethren, he who devotes himself to the relief of suffering humanity in frontier settlements surely earns the brightest crown. The remarks of the president of the American Medical Association, at its last meeting, on the 'pine-board hut' which served as home and office for the doctor of a Rocky Mountain railroad station, apply with equal cogency to hundreds of our profession. To our mind arises the face of a valued friend, a pupil of the illustrious Niemeyer, who devotes his life to an almost missionary work among the Mexicans. Separated from his home and kinsmen, undeterred by the pangs of hunger or fatigue, undismayed by the dangers of field or flood, by day and by night, he renders to the ignorant and superstitious inhabitants professional services which in older countries would secure to him the smiles of fame and fortune."

Dr. M. H. Henry, we are glad to learn, has been appointed by the commissioners of emigration surgeon-in-chief of the State Emigrants' Hospital, Ward's Island. Dr. Henry succeeds Dr. Carnochan, who has held this position for many years. The new incumbent is a gentleman of high standing and large experience in his profession. He served with distinction as a surgeon in the navy during the war, and as the editor of the Journal of Syphilography and Dermatology is well known to the profession throughout the country. A New York paper, speaking of the appointment, says: "Dr. Henry brings to his new position, which is one of great responsibility, an amount of talent, learning, and skill which are too often wanting in those who are called upon to serve the public in high places. The appointment is in every way one fit to be made."

THE UNIVERSITY OF MICHIGAN PURGES ITSELF—THE HOMEOPATHS BROUGHT TO GRIEF.—The friends of legitimate medicine every where will be gratified to learn that the homeopaths are not after all to hold professorships in the school at Ann Arbor. The legislature of the state of Michigan passed the law requiring the appointment of the "infinitesimals," but the board of regents declined to execute it. The supreme court of the state refused to grant a mandamus requiring the regents to comply with the law, whereupon the latter met and passed, with but one dissenting voice, the following very dignified and sensible resolution: "That we maintain the position heretofore taken, and decline to make the appointments required by law; that we do this in no spirit of factious opposition to the apparent will of the legislature, but because we believe the true and best interests of the university demand it; that we reaffirm the former action of the board expressing a willingness to take official charge of an independent school of homeopathy, and connect it with the university, whenever the means shall be provided for the payment of professors."

COLLEGE OF PHYSICIANS AND SURGEONS.—A medical society under the above name was recently organized in Little Rock, Ark., and the following officers elected: Dr. Geo. C. Hart, president; Dr. A. L. Breysacher, vice-president; Dr. E. V. Denell, treasurer; Dr. J. H. Lenow, secretary and librarian.

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* Any of these works may be procured on application to Messrs. John P. Morton and Company, Louisville, Ky.

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